there was no washing-out period for the subtenon steroid administered. Hence, out of the six patients enrolled, four of them (66.7%) might undergo the antihypotony surgeries superimposing with the ongoing anti-inflammatory effect of the subtenon steroid depot. This is a significant confounding factor. These inadvertently overlapped medical and surgical managements may blur the attribution that the observed postoperative improvement was solely due to surgical manipulation. If uncontrolled, it may imperil the reproducibility of the proclaimed intraocular pressure-stabilizing effect of the surgery. We would like to learn more from the authors about their precautions against this important confounding influence.

Acknowledgements

Financial and proprietary interest: Nil
Financial support: Nil

References

1 Paganelli F, Cardillo JA, Melo Jr LA, Oliveire AG, Skaf M, Costa RA, Brazilian Ocular Pharmacology and Pharmaceutical Technology Research Group. A single intraoperative sub-Tenon's capsule triamcinolone acetonide injection for the treatment of post-cataract surgery inflammation. *Ophthalmology* 2004; **111**: 2102–2108.
2 Lafranco Dafflon M, Tran VT, Guex-Crosier Y, Herbort CP. Posterior sub-Tenon's steroid injections for the treatment of posterior ocular inflammation: indications, efficacy and side effects. *Graefes Arch Clin Exp Ophthalmol* 1999; **237**: 289–295.
3 De Smet MD, Gunning F, Feenstra R. The surgical management of chronic hypotony due to uveitis. *Eye* 2005; **19**: 60–64.

DTL Liu, C-L Li and VYW Lee

Department of Ophthalmology and Visual Sciences, The Chinese University of Hong Kong, Prince of Wales Hospital, 147 Argyle Street, Hong Kong SAR, China

Correspondence: DTL Liu,
Tel: +86 852 2632 2878;
Fax: +86 852 2648 2943.
E-mail: david_tlliu@yahoo.com

Eye (2006) **20,** 1373–1374. doi:10.1038/sj.eye.6702207; published online 9 December 2005

Sir,

An evaluation of photographic screening for neovascular age-related macular degeneration

We read with great interest the work of DAL Maberley *et al*[1] on the 'Evaluation of photographic screening for neovascular age-related macular degeneration'. The authors were looking at the utility of colour fundus photographs for identifying subjects with potentially treatable neovascular AMD. While the methods, analysis and conclusions of the study seem both convincing and sound, the following is a suggestion, although meager, we feel could be of value to the authors.

DAL Maberley *et al* used Kodak-chrome colour slides for both stereoscopic and nonstereo images. Although important in both documentation and diagnosis, the 35 mm colour fundus photos are slowly loosing their allure in retinal imaging. Colour slides are being replaced by the technologically more advanced digital fundus photography. This imaging tool used to give a less detailed picture in the past when compared to 35 mm, however, with the recently available 6.0 megapixel cameras, resolution of the photos has been comparable if not superior to traditional cameras. Even reference reading centres, such as the University of Wisconsin Reading Centre is gradually switching to high-resolution digital photography, replacing the gold standard 35 mm slides. Advantages in digital photography comprise better manipulation of the fundus image, including magnification and colour filtering, and easier electronic storage/e-mailing. Finally, despite an initial higher cost, the digital camera's on going financial burden is by far less than film. We suggest to our authors embarking on digital photography (stereo and nonstereo) for projects to detect retinal pathology. This was proven both valuable and effective in ample studies.[2–4] Also, by using the different image manipulation tools, the authors then might achieve an even higher sensitivity and specificity than the one reported.

References

1 Maberley DAL, Isbister C, Mackenzie P, Aralar A. An evaluation of photographic screening for neovascular age-related macular degeneration. *Eye* 2005; **19**: 611–616.
2 van Leeuwen R, Chakravarthy U, Vingerling JR, Brussee C, Hooghart AJ, Mulder PG *et al*. Grading of age-related maculopathy for epidemiological studies: is digital imaging as good as 35-mm film? *Ophthalmology* 2003; **110**: 1540–1544.
3 Merrin L M, Guentri K, Recchia CC. Digital detection of diabetic retinopathy. *J Ophthalm Photography* 2004; **26**: 59–66.
4 Bursell SE, Cavallerano JD, Cavallerano AA, Clermont AC, Birkmire-Peters D, Aiello LP, Aiello LM, Joslin Vision Network Research Team. Stereo nonmydriatic digital-video color retinal imaging compared with Early Treatment Diabetic Retinopathy Study seven standard field 35-mm stereo color photos for determining level of diabetic retinopathy. *Ophthalmology* 2001; **108**: 572–585.

H Salti and J Khoury

American University of Beirut, Beirut, Lebanon

Correspondence: H Salti,
American University of Beirut, Ophthalmology,
AUB, Bliss Street, Beirut, Lebanon 113-6044, Lebanon
Tel: +9611 350 000;
Fax: +9611 744 464.
E-mail: hs06@aub.edu.lb

Eye (2006) **20,** 1374–1375. doi:10.1038/sj.eye.6702209;
published online 2 December 2005

Sir,

Response to Drs Salti and Khoury

We thank Drs Salti and Khoury for their thoughtful comments. Certainly, digital imaging is taking an increasingly prominent role in the setting of retinal imaging and we expect that this approach will ultimately replace film imaging. However, for our study, we were interested in answering two specific questions that made film imaging preferable. First, as there is little published data on the evaluation of colour fundus photos for the identification and triage of neovascular AMD, we were interested in determining if this concept was viable. Hence, we desired to use 'gold-standard' imaging and not to introduce a second variable, that of digital imaging. Second, our goal was to evaluate both stereo and nonstereo images sets and, for this purpose, Kodachrome stereo imaging is well-established—digital stereo imaging techniques are still evolving. We also like to caution readers about the use of digital manipulation tools during the process of image interpretation. Depending on the algorithms used, data and potentially diagnostic accuracy, can be lost with contrast enhancement tools and sharpening filters.

D Maberley

Department of Ophthalmology, University of British Columbia, Vancouver, Canada, BC

Correspondence: D Maberley,
Department of Ophthalmology,
University of British Columbia, Section C, 2550 Willow Street, Vancouver, Canada BC V5Z 3N9
Tel: +604 875 4599;
Fax: +604 875 4699.
E-mail: crtg_vancouver@hotmail.com

Eye (2006) **20,** 1375. doi:10.1038/sj.eye.6702210;
published online 6 January 2006

Sir,

Decentration of a foldable single-piece acrylic IOL within the capsular bag

Decentration of intraocular lenses (IOLs) may cause diplopia and functional aphakia. In-the-bag fixation and an intact curvilinear capsulorrhexis are advocated to minimise decentration.[1,2] Sunset syndrome refers to cases where capsular or zonular disruption allows downward IOL displacement.[3] We describe a case of sunset-like decentration due to optic–haptic adhesion, in the presence of intact zonules and in-the-bag fixation.

Case report

Following routine phacoemulsification, a single-piece acrylic SA60AT IOL (Alcon Ft Worth, TX, USA) was injected into the capsular bag using a Monarch cartridge. During insertion, the haptic was noted to be folded behind the optic. The optic appeared to be centred at the end of surgery.

At 1 month postoperatively cystoid macular oedema was noted, but no comment made regarding IOL centration. At 2 months postoperatively, the optic was noted to be decentred 2 mm inferonasally within the capsular bag. No zonular disruption was detected (Figure 1). The capsulorrhexis was well centred in the visual axis.

To reposition the IOL, the capsule was separated from the optic with viscoelastic. When the IOL was freely mobile, optic–haptic adhesion was noted. The adherent haptic was released, resulting in recentration of the lens (Figure 2).

Comment

Injectable IOL implantation is popular due to ease of insertion, smaller incision size, and avoidance of IOL contact with the external eye. Hydrophobic acrylic IOLs are favoured as they induce less capsular fibrosis.[4] In comparison to three-piece IOLs, optic–haptic adhesion may be more common with one-piece acrylic IOLs due to stickiness and flexibility of the haptics.

Implantation with the Monarch cartridge requires the haptic to be purposely placed on the optic, and the IOL undergoes compression and rotation within the cartridge. Compression of the IOL may be increased by a tight incision, and viscoelastic may influence optic–haptic adhesion. Asymmetric capsule contraction, when there is incomplete capsulorrhexis apposition to the optic surface, may exacerbate optic decentration. Late reopening of the capsular bag is more difficult with acrylic biomaterials due to tenacious capsule–optic adhesion.[5]